DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10989

Registration District No. 318 — Primary Registration District No. 2001 — Registrar's No. 287

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year (Specify whether days, months or years)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield (If outside city or town limits, write "RURAL")

(d) Street No. St. John Hosp. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME Dean L. Moist 23P

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. (Month) 10 (Day) 1885 (Year)

8. AGE: Years 54 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Springfield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired

11. Industry or business ____

FATHER 12. Name A.L. Moist

13. Birthplace ____ (City, town, or county) Ohio (State or foreign country)

MOTHER 14. Maiden name Parker

15. Birthplace ____ (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Mrs. Walter Parker

(b) Address Blackwell, Oklahoma

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof March 21 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 3/21/40 (Date received local registrar) (b) Chas A. Klingle M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20 year 1940 hour 9 minute a. M.

21. I hereby certify that I attended the deceased from Jan. 1937 to Mar 20 1940; that I last saw h[illegible] alive on Mar 19. 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Intestinal Abstruction	1937
Due to: Unclassified retro peritoneal tumor	
Due to:	
Other conditions: Liver Metastasis (Include pregnancy within 3 months of death)	

Major findings: Of operations Intestinal Abstruction 1937.

Of autopsy Same.

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature J. P. Lemmon (M. D. or other) M.D.

Address Springfield Mo. Date signed 3-20-40

(Licensed Embalmer's Statement on Reverse Side)

50M-5-17-39
Rev. 5-17-39
1 x19511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.